Emflaza (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Duchenne muscular dystrophy ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. Was the diagnosis of Duchenne muscular dystrophy confirmed by genetic testing showing a mutation in the *DMD* gene? ***ACTION REQUIRED: Attach a copy of the laboratory report.*** ❑ Yes ❑ No
7. Has the patient tried treatment with prednisone? ❑ Yes ❑ No
8. Did the patient experience unmanageable and clinically significant weight gain or obesity while receiving treatment with prednisone? ***ACTION REQUIRED: Attach chart documentation of weight gain or obesity with prednisone treatment.*** ❑ Yes ❑ No *If No, skip to #11*
9. What is the body mass index while receiving treatment with prednisone? _____ kg/m^2
10. *For children/teens less than 20 years of age,* what is the body mass index percentile while receiving treatment with prednisone? _____ percentile
11. Did the patient experience unmanageable and clinically significant psychiatric or behavioral issues while receiving treatment with prednisone (for example, abnormal behavior, aggression or irritability)?
    ❑ Yes ❑ No *If No, skip to #14*
12. Did the psychiatric or behavioral issues persist beyond the first 6 weeks of treatment with prednisone?
    ACTION REQUIRED: Attach chart documentation of persistent psychiatric or behavioral issues with prednisone treatment. ❑ Yes ❑ No
13. Has a change in timing of prednisone administration been tried to manage the psychiatric or behavioral issues (for example, the dose is given in the afternoon or evening)? ❑ Yes ❑ No

14. Is this request for continuation of therapy with Emflaza? ❑ Yes ❑ No *If No, no further questions.*

15. Is the patient receiving a clinical benefit from Emflaza therapy, such as improvement or stabilization of muscle strength or pulmonary function? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**